Responses to Bidders' Questions Received as of July 20, 2006

I. General

1) Given that the RFP was received less than two months prior to the proposal submission deadline and due to the complexity of some of the requirements is there a possibility of pushing back the date the proposal submissions are due and the effective date of the program? ***We do not currently anticipate pushing back the due date for proposals, or the effective date of the program.***

2) C3b and c, Page 8: These sections state that, "the SCM program will serve high risk Medicaid clients…" and, "LCMs will enroll Medicaid and dual Eligible Medicare/Medicaid adults…" If there is no LCM in a given geography, will the SCM enroll and provide more comprehensive services for Medicaid-only and Dual Eligible clients? ***No, the SCM will provide services to high-risk, Medicaid-only clients in areas not served by an LCM***.

3) Page 8: Would the State consider a blended approach to care management whereby the SCM serves the high-risk members and collaborates with local community service organizations to provide care management services for the members determined to be moderate and low-risk? ***If there are no successful bidders to the RFP as issued, DSHS will consider a different approach.***

4) Is this program modeled after a successful program elsewhere? If so, may we have access to their program costs and any staffing challenges? ***This program contains elements of programs from several other states, but is not modeled as a whole on any other state's program.***

5) Page 6 of the RFP, Section I.A. states DSHS desire to solicit collaborative proposals from community-based agencies and entities with experience in providing care management to Medicaid enrollees. Is it therefore acceptable for one organization to submit a proposal to serve as both the Statewide Care Management (SCM) vendor as well a collaborator (but not the prime contractor) on a Local Care Management (LCM) program? ***This approach is allowed; each proposal will be considered separately.***

6) Is it acceptable for one organization to submit a proposal to serve as both the SCM vendor as well the prime contractor on a LCM program with community-based agencies as subcontractors? ***We will accept one proposal from each bidder – it is up to the bidder to decide whether to bid on a SCM or an LCM program.***

7) Page11 of the RFP, Section I.C.7. indicates LCM bidders will define their projected service area. What criteria will DSHS use to determine reasonable geographic boundaries (i.e. not too small to provide for insufficient client enrollment, or not too large as to encompass disproportionate percent of eligible clients), to avoid prohibiting sufficient collaboration and testing of care management models between the SCM and LCM? For example, could a LCM bidder indicate their service area is the entire state? ***No, a bid for the entire state***

would be considered a Statewide program. Local means a discrete geographic area within the state. The LCM bidders will be evaluated on their ability to prove capacity for medical home assignment for every eligible client in their defined service area. It is highly unlikely that an LCM would be able to provide medical home assignment for all CN aged blind and disabled clients in the state by January 1. LCM bidders should determine their boundaries after securing commitments from providers to serve as qualified homes for clients.

8) Page 13 of the RFP, Section I.D.1. discusses the LCM requirements. To assure a seamless, high quality approach for all enrollees, will the SCM be expected to provide the same types of services in those areas not served by a LCM (i.e. medical home provider networks, etc.)? Can DSHS please clarify if there are discrete activities an LCM will perform for enrollees that may not be offered to SCM enrollees through an effective community-based care management model? ***We want to test different approaches, so yes; expectations for LCM programs are different from those for the SCM.***

9) Page 10, I.C.5c.iv, Does DSHS expect that the SCM vendor will perform similar functions as the LCM by way of inputting information directly into the provider systems? ***That is not the expectation***.

10) Can there be an initial geographic service area with plans or contingencies for expansion of this area during the two year contract, upon further experience or recruitment of further participating providers? ***Yes, as long as the expansion does not overlap another LCM project's service area boundaries.***

II. Enrollment

1. Is there a ceiling to the number of members enrolled in a LCM? In a SCM? ***The number 2000 for enrollment was put forward by DSHS as the minimum number of enrollees we feel it would take to make a program successful financially. There is no pre-determined ceiling for enrollment for either LCM or the SCM program; we would expect bidders to include a proposed number of enrollees along with justification for that number in their proposal***.

2. Page 35 of the RFP, Section III.F.3 instructs vendors proposing to provide the SCM services to develop the Cost Proposal by "assuming approximately 5000 clients will be eligible for and managed in Local Care Management projects." What number of clients do you anticipate engaging in care management on a monthly average during the first year of operation? ***In the first four years of a more traditional disease management program, there were on average 20,000 clients identified with target conditions at any given time. However, the participation rate in most disease groups was less than 50%. So, we anticipate fewer than 20,000 enrollees will be engaged in one of the programs in the first***

year. We will have a better idea of the target population for high risk when the predictive modeling is done.

3. Exhibit B, Descriptive Data-AB, GA-X Medicaid Case load count and Average MA Expenditure Data (page 46) indicates a potential total population available for care management statewide by the SCM. Is the total of 180,735 less 5,000 that is project to be managed by the LCMs? ***No. 180,000 include duals, who are not assigned to SCM. For the purpose of proposing rates, estimating staff needs, etc., the SCM should assume 60,000 eligibles from which the high risk pool will be drawn. SCM only manages high risk clients; you will need to propose an estimate of manageable high risk clients.***

4. To accurately provide an estimate of the number of clients the SCM may engage on a monthly average, could DSHS provide an assumption of the number of clients that will be eligible in the geographic areas served by the SCM project? ***See above.***

5. Is there a firm date that bidders will receive more complete claims data to determine projected enrollment and projected case load? ***Historical claims will be provided on August 1. These data should be considered to reflect the typical utilization of Aged, Blind, and Disabled clients, but is not the actual eligible client population you would receive for enrollment. The data for enrollment would be delivered later in the Fall to successful bidders.***

6. Will DSHS provide some further guidance and common assumptions on the number of enrollees that are expected to be engaged in order to assure comparability of pricing information? ***See above.***

7. P. 8, I.C.3, What is the estimated number of potential participants statewide? Are SMIs included? If yes, how many SMIs does the state assume will be included? The State recently posted summary information on its web site and included summary data in Exhibit B that seems to be inconsistent. Can the state clarify or help reconcile this data? ***We would need to know which data appears in consistent. However, again, for SCM the potential is approximately 100,000 over a year. The diagnosis categories are broken out according to medical claims in Exhibit B.***

8. A1, Page 6: Would the State please clarify if this voluntary program will require members to "opt-in" or "opt-out?" Or may the bidder propose an approach? ***Bidders should include this in their proposal, along with reasoning why their approach might make the project more successful. Dual eligibles would not be able to be in an "opt-out" enrollment process.***

9. A2a, Page 6: For each of the local pilot programs designated for local care management (LCM), it is anticipated that a successful program will have at least 2,000 potential enrollees. Does DSHS have an optimal number of enrolled

eligibles targeted for each pilot program that is based on the geographical, economic, and other factors? ***The optimal number is small enough for the bidder to reach 100% of eligible clients to offer the program, connect to medical home, test the approach; big enough to see changes in outcomes within a 2 year pilot.***

10. C3b and c, Page 8 Would the State please clarify if it is the intent of the State that the SCM provide care management services for only those members determined to be high-risk while the LCM(s) provide care management services for all Dual Eligible Medicare/Medicaid adults who are Categorically Needy, Aged, Blind and Disabled? ***Yes, this is a correct assumption.***

11. C3aiii and c, Page 8 Would the State please clarify if members eligible for the Healthy Options managed care program are also eligible for enrollment in either the SCM and or LCM? ***Clients who are eligible for enrollment in Healthy Options (i.e. Temporary Assistance for Needy Families – TANF) are not eligible for this program***.

12. C3aiii and c, Page 8 Would the State please provide a listing of all counties who have mandatory enrollment for Medicaid eligible members to be in the Healthy Options care management program? ***Medicaid clients who are eligible for Healthy Options are not eligible for this program; however, we have attached a list of counties in which enrollment in Healthy Options is mandatory.***

13. The target population, as defined on page 8, excludes "clients who are eligible for enrollment in the Department's Healthy Options managed care program." Does this exclusion apply to clients who are permitted to enroll under the Medicaid Fee for Service system due to special needs, continuity of providers, or limited Healthy Options contractors or providers in their area? ***Clients who are eligible for Healthy Options are not eligible for this program. See questions 11 and 12 above.***

14. On page 6 in section A.2 of the RFP, there is an estimate of the number of potential enrollees in the Local Care Management (LCM) projects. Is there a similar estimate for the Statewide Care Management (SCM) project? ***See above, approximately 60,000 in the pool from which to draw the high risk.***

15. On page 8 in section C.3 of the RFP, there is a description of the populations that are excluded from this project. If a Medicaid client is enrolled with the LCM or SCM and after enrollment starts to receive hospice services, how does this impact the LCM or SCM in working with those individuals? ***If a client enrolled with either and LCM or the SCM elects to receive hospice, the LCM/SCM will disenroll the client and work with the hospice program to ensure a smooth transition for the client.***

16. Are individuals who are SSI or SSDI eligible for services from the LCM or SCM? ***Yes, that is the target population.*** In sub-section c, there is an indication that the LCMs can receive referrals from providers. Can the SCM also receive referrals from providers, social workers, and other professionals for individuals not included in one of the LCM programs? *Yes.*

17. Please clarify the enrollment process. Once someone is identified by the SCM as being appropriate for the program, does DSHS process the enrollment (as indicated in Section E) and obtain agreement from the enrollee or do the LCMs/SCMs enroll the person themselves as indicated Section C. 5? ***We are open to a program which uses an opt-out method of enrollment for Medicaid clients. The SCM clients would be enrolled based on eligibility category. Should a client be enrolled in another program, LCM or other, those programs would take priority. The SCM clients would have the ability to opt-out. The LCM could also auto-enroll clients for the purpose of supporting the medical home infrastructure. The LCM dual clients would need to be opted in. Client(s) are enrolled for the prospective month. A capitation payment is based upon that enrollment. For Care Management clients, the selected bidder(s) would need to send some kind of specified client list to DSHS on a fixed date prior to cut-off that gives enough time to validate information***.

18. Section 6 a. ix. refers to the transition of enrollees who graduate from care management. Are the parameters for "graduation" to be set by the LCMs? Once graduated are the enrollees then transitioned back to regular fee-for-service Medicaid? ***Parameters for "graduation" should be included in the LCM proposal, along with a plan for allowing clients to maintain their connection with the program if needed. Additionally, clients who have been connected with a medical home should continue to be associated with the medical home after graduation.***

19. Section III E. 11 addresses the transfer of care management responsibilities to the medical home after the enrollee graduates from CM. Once the member graduates from the program the assumption is they leave the program and no longer get the services of the program. Is this correct? *Yes for SCM's*. Is there a requirement that the medical home continue to provide care management to the person even after they are no longer in the program. Please clarify what is meant by this section. ***The LCM will have ongoing responsibility for the medical home aspects of the program. Also see the Funding section for instructions on how to price this aspect of the program***.

20. Is there an allowance for enrollees to re-enroll in the program? ***Yes*** If so, is there a waiting period and how long is the waiting period? ***There is no waiting period.***

21. How are enrollees who are referred by providers entered into the system? Are they simply reported by the LCM as participating? ***Yes. They would then be enrolled in the system.***

22. What is the provision to allow enrollees the LCM enrolls or who are referred by community providers to be "modeled" by the SCM system in order for the LCM to obtain the risk categorization and recommendations for that enrollee? ***The SCM will get all data on all clients.***

23. Page 6 of the RFP, Section I.A.1. indicates the Chronic Care Management Project is a "voluntary program." Can voluntary enrollment be confirmed by communications with eligible clients, with sufficient information to permit clients to opt-out of the program voluntarily? ***That is an option for Medicaid only clients.***

24. Page 8 of the RFP, Section I.C.3.c. indicates LCMs will enroll Medicaid and Dual Eligible Medicare/Medicaid adults who are Categorically Needy, Aged, Blind and Disabled. Will SCMs enroll this same population in areas not served by the LCMs? ***No, Medicare eligibles will not be auto-enrolled, and their data will not be sent to the SCM for Predictive Modeling.***

25. Can a bid specify any limitations on the scope of clients to be served other than residence in a defined geographic service area? ***Other than the eligibility categories described in the RFP bidders may not place limitations on the scope of clients to be served by the program .***

26. Page 8, I.C.3 How many Medicare/Medicaid dual eligible beneficiaries participated in the disease management program, and how many are anticipated to participate in the chronic care management program? Will the DSHS consider expanding the participant pool for this program to include dual eligibles? ***Dual eligible clients were excluded from the previous disease management program via a 1915 (b)(4) waiver; the pool of eligible clients for the LCM program will include dual eligibles.***

27. Page 8, I.C.3.a Are SMIs an included or excluded population from participation in this program**?** ***SMIs (people with serious mental illness) are included***.

28. Page 8, I.C.3.b What role does the SCM play in coordinating enrollment as people move from one geographic area to another? ***If the SCM becomes aware of an enrollee moving from one geographic area to another, the SCM could either refer to the appropriate LCM (if there is one) or enroll the client in the SCM program***.

29. Page 9, I.C.5.a Will it be the responsibility of the LCM vendors to provide the SCM vendors or the State with a list of enrollees that have agreed to participate in the program in order to compare to any new list generation from predictive modeling? ***Yes, we will need to have your list of enrollees in order to pay accurately.***

Responses to Bidders' Questions Received as of July 20, 2006

III. Case Management

1. Is there a difference in the medical home requirement between LCMs and SCMs? ***Yes. LCMs will be required to assist enrollees in finding a medical home; the SCM may provide assistance if requested by an enrollee.***

2. Does an enrollee's refusal to participate in the medical home aspect of care result in disenrollment? ***No, a client's refusal to participate in the medical home aspect of the program would not result in disenrollment unless the client asked to be disenrolled. If you have a client in the care management program, you will need a working relationship with their primary care provider. We would expect that the LCM attempt to build working relationships with the PCP's their clients consider a medical home. That being said, the client can choose to see a PCP not in your "network".***

3. Long-term care services are excluded from this pilot, but it will be necessary to coordinate with the agencies and providers of these services. What provisions will be in place to foster/allow for this coordination of patient information? Or will clients receiving these services be excluded from the program? ***Bidders will need to know the resources for LTC in the community in order to refer to them if needed. Once clients begin receiving LTC services, they are excluded from the program.***

4. Section D. 2 indicates that either a PCP or care management nurse must be available for emergencies. What is meant by "available"? ***Available means if the enrollee has an emergency he or she will not get voice mail – a live person must be available to help***.

5. Beyond the joint visit to the PCP within the first two months of enrollment, is there a requirement for the number of face-to-face visits for the LCM model? ***Bidders should describe how the face-to-face visits will occur and what circumstances would trigger a face-to-face visit.***

6. Is there an expected level of case management contact per enrollee? ***LCM bidders should allow for at least monthly contacts, either via telephone or face-to-face and should describe circumstances in which contacts might be more frequent.***

7. Is there a provision for providing care management services to clients who are determined not to be high risk or will those clients not be enrolled? ***Yes in LCMs, no in SCM.***

8) Please clarify what is meant by the definition of "medical home". ***Please see definitions for Medical Home and Primary Care Provider in RFP.*** Can this be a

single provider? Can it be a specialist or a nurse practitioner? ***See definition. Yes, if those providers are willing and able to meet the needs of the enrollee.***

9) What are the expectations of accepting referrals from professionals? Does the LCM/SCM make the determination if the client is appropriate for the program and may they refuse enrollment if the referral is determined to be inappropriate? ***No, the LCM must accept all eligible clients; the SCM can refuse if on assessment the client is not good candidate.***

10) Section C.5.e – LCM & SCM contractors are required to link enrollees to a medical home if the enrollee does not already have a provider. Will DSHS identify to the SCM (& the SCM to the LCM) those provider(s) with whom the enrollee has established a relationship? ***DSHS will be providing claims data which may help in identifying primary care providers.***

11) Does the joint visit (I. C. 5. c. ii) require in-person presence of the LCM care manager? ***Yes, we would expect the care manager to accompany the enrollee to at least one appointment.***

12) Page 10 of the RFP, Section I. C.5.b.iii.addresses time-limited enrollee education and states "ideally, care and education plans will be limited to six months, with one or two three-month extensions for highest risk enrollees if necessity is documented according to the Contractor's DSHS–approved policies and procedures." Can the SCM propose graduation criteria and other criteria for ongoing care management of clients at high risk of medical costs beyond the time-limits proposed? ***Yes, we would expect there to be such criteria.***

13) Page 13 of the RFP, Section I.D.2. requires, with respect to "participating providers in LCM contracts", that "the PCP or care management nurse [is] available for emergencies." Can DSHS please describe in more detail what type of availability is expected in emergency situations? Is the care management nurse referred to anticipated to be on staff with the care management entity or the participating medical home provider*?* ***Either the PCP or covering MD or a nurse consultant must be available 24 hours a day. "On staff" or not is part of your proposal.***

14) Page 14 of the RFP, Section I.D.3. indicates care management services must be provided through staff "including at a minimum BSN level Registered Nurses." Section I.C.7 (page 11) only indicates "the principle care manager must be an RN." Can DSHS please clarify if BSN level RNs are required to do all care management services, for both the SCM and LCMs, or whether BSN level RNs must be part of the overall complement of care management staffing? ***No, BSN level RNs are not required to provide all care management services. Yes, BSN level RNs must be part of the overall complement of care management staffing. Please describe in your proposal how your staffing model will reflect the necessary skills, knowledge and abilities that are necessary. If nurses do not***

have BSN degrees, what level of competency in community health or case management will be expected in order to hire them?

15) **p. 13, Section D.3** -- Would DSHS be willing to consider RNs who are licensed in Washington, but who do not hold a BSN degree? ***Bidders may have a mix of BSN and non BSN nurses, with a projected proportion.***

16) The RFP mentions that case management shall be performed by a BSN level nurse. In our market, there are both BSN and RN (two and three-year) nurses performing the same level of case management requiring the same level of clinical judgment. We would argue that the supply of qualified case managing nurses who have adequate clinical experience is not vast. Would not the proposed project be better served to allow case managing nurses to have an RN degree and also two or three years of case management experience, regardless of whether they hold a BSN? ***Yes, you may include a mix in your proposal.***

17) On page 14 section D.3, there is discussion regarding the educational and licensing requirements of nurses. Can the nurses have a bachelors degree in an area other than nursing and/or a specialty certification (e.g., certified case manager) while still meeting the minimum qualifications? ***Please describe your proposed mix of staff and requirements in the proposal.***

18) **p. 9, Section C.5.b.i-ii --** Could DSHS clarify its expectations for "in-person capacity" for nurse intervention and enrollment? For example, would DSHS expect the successful SCM bidder to provide in-person services throughout Washington, with the exception of the areas served by the pilot programs? ***Yes*.**

19) **p. 13, Section D.3** -- Would DSHS clarify which aspects of enrollment and referrals may be performed by "lay health workers"? ***Non-clinical tasks, such as: Initial contact, non-clinical assessment of needs, referral to non-clinical resources e.g. transportation.***

20) Page 29, III.E.2.B.2 At what point does the State anticipate a client's six month participation time period to begin – upon when the individual care plan is approved by both the client and provider or another point in time? Depending on that point in time selected, how will an LCM be paid for interactions with a client between that point in time and notification of program eligibility from the SCM? ***We expect bidders to propose a timeline for how the process would work – the six months could begin at any of these times; tell us why one would work better than another. Also see questions and answers about Funding.***

21) What flexibility might the State have in the qualifications for care managers other than being a degreed Registered Nurse licensed in the State of Washington? ***This information should be included as part of your proposal - how you would use mixture of staff.***

22) On page 8 in section C.4, there is discussion regarding the identification and referral of targeted populations. Are there other methods by which the LCMs and/or the SCM can be notified in a more "real time" method rather than waiting for the claims data to be submitted? This may include notification from Washington Medicaid, or its contractor, at the time a patient is admitted to a nursing home or hospital. ***If a client is admitted to a nursing home for long term care, the client will be disenrolled from the program. The LCM or SCM would be notified on the next month's client roster. It would be a benefit for LCM's to build relationships with local hospitals so that the LCM is notified by the hospital when a client is admitted. The SCM would have a more challenging task with this.***

23) In addition to being licensed in the state of Washington, do the care management nurses for the SCM also need to reside in the state of Washington? ***No.***

IV. SCM Specific Questions

1. Will the SCM have access to pharmacy data for predictive modeling? ***Yes***

2. Page 28, III.2.A.5.c.ii, What does the State mean by "Allow specification of matching criteria for comparison groups?" What is the State's expectation from offerors? ***The State is interested in estimating the cost impact of the targeted interventions to improve care. In general, a comparison of pre-intervention and post-intervention costs for clients in the intervention group will not be adequate to estimate cost impacts, especially if clients in the intervention group tend to be high-cost clients in the identification (pre-intervention) period. This is due to the well-known phenomenon of "regression to the mean." To more credibly estimate cost impacts, it is desirable to have a comparison group of "similar" clients and to use a "differences-in-differences" approach (pre vs. post, intervention vs. comparison group) to estimating cost impacts.***

In the differences-in-differences framework, it is critical that the comparison group be "comparable" to the intervention group. An important dimension of "comparability" will be the criteria used to identify clients as appropriate for the intervention under consideration. As such, we expect that the offeror's predictive modeling capacity will facilitate the identification of comparison groups of clients who are "similar" to clients who have been identified for an intervention.

3. Page 28, III.2.A.7 Referring to the proportion of all potentially eligible participants, is the State asking the offeror to submit an analysis from the data disk to be provided, or of an offeror's current experience in other markets? ***We would like the bidder to submit their analysis of the data we provide.***

4. Page 29 III.2.A.11 - Is the State referring to the initial transfer, or transfer after the client is assigned? ***If this process will be different in each case, please describe both.***

5. On page 10 in section C.5.c, there is discussion regarding the required interventions for the LCM. Is the SCM required to "enter enrollee-specific data directly into the provider's information system or directly into the enrollee's medical record? ***No.***

6. What format will the claims data sent to the SCM be in? Please provide file layout information/specifications. ***We will provide a file layout with the data file August 1. The routine data fields will be negotiated with the bidder, so the file layout is not final. The previously used version will be made available at the bidders' conference. The file layout for payment will be the standard 820/834 format.***

7. Does the SCM make the determination as to when an in-home intervention is required for its covered enrollees? ***Yes, this should be part of your proposal***.

8. Where did the 6-month interaction period come from? Is there evidence that this limited and short-term approach has sustained impact on enrollees' health status? ***The six month interaction period came from the Indiana model. There is evidence that this approach has an impact on enrollee health status.***

9. What level of approval is there from the state as to the risk classification of enrollees? Is this limited to the review of the predictive modeling software? ***We are not as concerned with the model imbedded in the software as we are with the result of the predictive modeling. We will want to understand fully how the results of the modeling are used to select clients for care management.***

10. What requirements and service level agreements will be placed on the SCM contractor to provide timely referrals to the LCM Contractor based on the SCM Contract's use of predictive modeling of DSHS eligibility and claims data that identifies clients appropriate for enrollment in the LCM program? (Page 8) ***Contract terms have not been written. We assume a reasonable expectation would be a 2 week turnaround of data after each submission of data to the SCM***.

11. Page 6 of the RFP, Section I.A. 2. b. indicates that DSHS will award a SCM contract to provide services described in this document to enrollees who do not reside in the areas being served by one of the selected pilot projects. Since the SCM bidder will not know the geographic areas until the LCM bids are submitted and awarded, for purposes of the bid response how should the SCM bidder estimate the number of target individuals that will be in its service area? ***Assume 5000 clients carved out to LCM's.***

12. While we understand DSHS is not requiring interventions by specific disease category, will DSHS provide a target estimate for this Aged, Blind, and Disabled population by disease category and location? ***No, this information should emerge from Predictive Modeling.***

13. Page 8 of the RFP, Section I.C.4. addresses how the SCM receives eligibility and claims data from DSHS and subsequently refers "clients who are at risk for greater medical costs" to the appropriate LCM program. To promote the Institute of Medicine's patient-centered model of disease management, can the SCM include activities designed to support medical homes outside of the geographic areas covered by LCMs? ***Yes.***

14. Page 9 of the RFP, Sections I.C.5.b.i. and I. C.5.b.ii. advise that the SCM contacts will be mainly telephonic for enrollment and education with in-person nurse intervention for high-risk enrollees. Is it permissible for the SCM to also deploy alternative community-based, consumer-directed approaches for engagement and education that promotes clinical improvement consistent with the Chronic Care Model? ***Yes.***

V. LCM Specific Questions

1) Does the LCM have to accept all clients referred by the SCM? ***Yes.*** What are the provisions for the LCM to provide feedback on enrollment if the LCM finds that assignments are not appropriate? ***We would expect that LCM contractors will have ongoing contact with the SCM, and that dialogue would take place during a regular contact.***

2) Question 12 in Section III 3. C. asks how the LCM will coordinate care for enrollees whose provider is not participating. The assumption was that enrollees would need to be assigned to a medical home, meaning that the provider would have to participate. Please clarify the expectations for providing a medical home versus providing care management for enrollees seen by non-participating providers. ***If a client already has a medical home, he or she may choose not to participate in the medical home portion of the program; however, the client may still benefit from receiving care management services and should be given the opportunity to participate for care management only.***

3) Are the geographic service areas for the Local Care Management programs (LCMs) required to be contiguous? ***Yes***

4) Can a single Bidder be awarded a contract for Local Care Management (LCM) program to cover the three local pilot projects? (Pages 6 and 11) ***If a bidder submitted a bid for all three LCMs, each area would be considered separately,***

and would be awarded based on the merit of that proposal versus other LCM proposals.

5) Can a single Bidder be awarded a contract for Local Care Management (LCM) project by using a consortium of "medical homes" not in the same geographic area. For example, a consortium of medical homes that include clinics in several counties of the State. (Pages 6 and 11) ***No. The medical home must be accessible to clients where they live.***

6) If fee-for-service clients currently have a physician and are receiving care at a community healthcare center would those patients have a choice to keep their same physician if that physician is part of the LCM Network? (Page 11) ***Yes, the client may choose to keep their physician whether the physician participates in the project or not.***

7) Is there any expected interaction between the LCM program and the current/revised state behavioral health programs under a Regional Support Network (RSN) to maximize care of the Aged, Blind & Disabled Medicaid clients? (Page 8) ***Yes. We expect ongoing contact between the LCMs and the RSNs, and would expect cooperative relationships to be built.***

8) Will LCM Contractor(s) have access to reports from SCM Contractor's predictive modeling? (page 8) ***Yes.***

9) Please clarify expectation of how claims for providers in an LCM program will be paid and whether this remains a DSHS responsibility (Page 14-E "Funding") or is an LCM Contractor responsibility (Page 14 E-1). ***DSHS will continue to pay claims.***

10) P. 8, Section C.1 – If DSHS awards to only LCM bidders, how will the State identify and refer clients to the LCMs. ***Clients will be identified using diagnosis and procedure codes, historical cost of services, etc.***

11) Will all Medicaid enrollees meeting SCM predictive criteria with addresses in the region be referred to the contractor, regardless of the proposed provider network? ***Yes.***

12) C5cii, Page 10 What would be the rationale for DSHS in requiring the LCM to provide at least one joint member visit to the primary care provider within the first two months of enrollment? ***This approach was very successful in the Indiana model, in which the nurse care manager attended an appointment with each enrollee. The goal is for the nurse to model good "appointment" behaviors for the enrollee and teach the enrollee the kinds of questions he or she should be asking about their condition.***

VI. Providers

1) Please confirm that providers need not be contracted with nor credentialed by a health plan bidding for the contract. ***Correct.***

2) To document a provider's commitment to participate, would a non-binding letter of intent be acceptable? ***Bidders must provide evidence that the bidder's network of potential medical home providers is adequate for the level of enrollment.***

3) Are the fee schedules or other provider payment bases the responsibility of the Statewide Care Management program (SCM) and LCM contractors? ***DSHS will continue to pay fee-for-service medical claims to providers; any other payments made to providers will be the responsibility of the Contractors.***

4) Page 11 of the RFP, Section I.C.6.b addresses provider activities to be conducted by the SCM. Can the SCM include reporting of client participation, enrollees' condition and utilization data to providers in addition to DSHS (see Section I.F – Evaluation and Reporting), in order to support medical homes outside the geographic areas covered by LCMs? ***Yes***

5) Page 11 of the RFP, Section I.C.7 states "LCM contractors are expected to establish payments to providers for medical-home services that align incentives with the delivery of high quality evidence-based care." Will DSHS allow incentives, consistent with the Chronic Care Model, that promote high quality evidence-based care for those areas not served by an LCM? ***Yes.*** How does DSHS with to see these incentives be funded (e.g. additional Medicaid reimbursement, payment through LCM/SCM, etc)? Is there a proposed budget amount for these payments? ***Any incentives paid to providers will be the responsibility of the Contractors. Proposals should include details about whatever payment the bidder thinks would be sufficient. The overall budget would include those payments, they will not be paid separately by DSHS.***

6) Page 14 of the RFP, Section I.E. states, "LCM contractors shall be paid for all enrollees assigned to medical homes in the program within the eligible population (Categorically needy, Aged, Blind, Disabled and Dual Eligible – Medicaid/Medicare)." Can DSHS please provide detail on how the LCM needs to document the establishment of a medical home? Are there similar requirements for an SCM that would promote medical homes in geographic areas not covered by an LCM? ***We would expect to see documentation on an individual client level that includes the client's consent to participate in the medical home aspect of the program, and the provider to whom the client has been assigned. This documentation should be available for review by DSHS during monitoring visits. A summary report should be sent to DSHS on a monthly basis. Any clients who opt-out of the medical home aspect will need to be disenrolled, and***

that information passed to DSHS monthly. SCM will be required to assist clients to find a medical home and to provide information to providers about the clients' participation in care management activities.

7) Can providers be added over time after the bid has been finalized? ***Contracts will only be awarded if there are sufficient providers for the population in the bidder's geographic area.***

8) Is there a distinction between the bidder's "provider network" and the full list of providers receiving incentive payments? ***No, unless some providers are willing to participate with no incentive.***

9) Can incentive payments be negotiated that reflect differences among providers in such variables as specialized skills, "in-network" versus "out-of-network" status, willingness to accept additional primary care patients, willingness to adopt a greater number of care management or EBM practices, or other distinctions related to program goals? ***Incentive payments are between the bidder and the providers. You may negotiate them in whatever way your proposed providers will accept.***

10) E, Page 14: This section indicates that fees paid to the SCM and LCM contractors will include, "support for participating providers as medical homes…" Will contractors be expected to pay providers for their participation, such as in PCCM programs? ***You may pay providers in this manner if this is what works in your service area***. If so, will this requirement apply only to LCMs or also to the SCM if there is no LCM in the area? ***The Medical Home requirement is specific to LCMs; if SCM bidders feel that paying providers for participation would add value to the program, that element can be proposed in the budget***.

11) What is your definition of "participating providers." As it relates to the requirements on page 13. ***Participating providers are those who meet the "Requirements for participating providers…" on page 13 of the RFP.*** As it relates to having a CORE provider agreement with DSHS. ***Any provider to bills DSHS for medical services must have a CORE provider agreement in order to receive payment.***

VII. Funding

1. On page 14 in Section E, there is discussion regarding the fact that neither the LCM or the SCM projects will be at risk for guaranteed savings, but programs must be cost neutral. Do the LCM or SCM contractors have any impact financially if the DSHS or CMS determine their services are not cost-effective? ***No. These programs are not at risk.*** Does DSHS or CMS have specific cost savings methodologies that will be used in calculating cost savings, and if so, what are those calculations?

We had several questions on this topic, including: How will we measure cost neutrality? How will we measure cost effectiveness? How will the state deal with outliers? Please see answer below:

Answer: The State anticipates estimating cost effectiveness and determining cost neutrality by using a "differences-in-differences" approach to estimate the cost effectiveness of the projects. This approach involves comparisons of pre/post changes in service utilization and costs between the intervention and a matched comparison group. A key aspect of the approach is the selection of an appropriate comparison group of clients with baseline characteristics that are similar to the intervention group. Characteristics that will be considered for matching will include:

1. ***Demographic characteristics – age, gender, race/ethnicity***
2. ***Geographic location***
3. ***Baseline chronic disease profile***
4. ***Baseline service utilization***
5. ***Other available criteria as appropriate based on the nature of the specific intervention***

We anticipate using stratified random sampling using propensity score methods to select comparison group members. We anticipate using fee-for-service claims data to measure disease conditions and service utilization. We anticipate conducting sensitivity analyses to determine whether the cost effectiveness estimates are affected by the presence of outliers. The analyses may be performed by State research staff or by an external research organization.

1) What is the methodology for determining cost neutrality of the program (Section I.E.)? ***Please see question VII.1, above for the answer to this question.***

2) How will cost neutrality of the programs be determined? ***Please see question VII.1 above for the answer to this question.*** Will DSHS be reducing the PMPM paid to the LCM or SCM awarded in the bidding process if costs exceed the state's budget? ***We will not exceed a budgeted amount which will be clear in the contracting process.*** How will the state deal with outliers in determining this (ie. catastrophic cases which could reduce the savings in any given year, especially if this is a small population). ***The contract could set an upper limit on claims in the analysis.***

3) Page 14 of the RFP, Section I.E. states "neither the SCM nor LCM will be at risk for producing guaranteed savings, but programs must be cost neutral." How will budget-neutrality or cost-effectiveness be determined? Is this the sole responsibility of DSHS? ***Please see question VII.1. above for the answer to this question.***

4) General - Will the State please clarify the methodology to be used to quantify that the cost of the program is "budget neutral?" ***Please see question VII.1. above for the answer to this question***.

5) Section E states "All rates paid for services will be evaluated by DSHS and CMS staff for their cost-effectiveness." How will cost-effectiveness be determined? ***Please see question VII.1. above for the answer to this question.***

6) Section E states that contractors will only be paid for "active participants". What determines that a participant is "active" in the LCM model? In the SCM model? ***Active participants are those who have been engaged by the care manager and agree to participate. If you have not been able to reach them, or they do not agree to participate, they are not active. See also answer to question below.***

7) How is the payment for LCMs tied to the medical home assignment? What triggers the payment? For instance if a member enrolls and the LCM works to get the member assigned to a PCP, but the member does not comply in the month they are assigned, does the LCM get paid for that month? What if an enrollee refuses a medical home? ***Please prepare rates for two different categories of enrollees.***

   - ***For SCM bidders, one rate will be the Basic rate paid for all eligibles in the target population minus clients who live in the LCM areas. This rate will cover the Predictive Modeling, referral to the LCM, and reporting requirements for results of the Predictive Modeling. It will be paid as a monthly per capita fee across all eligibles who are potential care management enrollees, i.e. not enrolled in LCM projects (60,000 for purposes of the bid).***
   - ***For LCM bidders, one Basic rate should be proposed to cover the medical home infrastructure requirements. This will be paid on a per capita basis for all potential eligibles in the targeted geographic region, not currently enrolled in care management.***
   - ***Both bidders should propose a second rate for active participants in care management. Clients will be enrolled at either the Basic rate (SCM or LCM) or the Care Management rate (SCM or LCM) but no client will be enrolled in multiple rates or to multiple contractors. An auto-enrollment into the Basic category is possible, whereas clients will need to be actively managed in order to be enrolled in the Care Management rate.***

8) Are enrollees enrolled effective the first of the month? ***Clients will be enrolled prospectively into Basic, but could become active participants mid-month. The Care Management rate will be paid for the month after DSHS is notified that the client is actively engaged.***

9) When are payments made for covered enrollees? At the beginning of the month for those enrolled or at the end of the month for all enrollees? ***At the beginning of the month for those enrolled.***

10) Is the SCM/LCM required to bill DSHS for active participants? ***No.*** If so, what form is to be submitted for payment? Is there an electronic option? ***Yes, payments will be made electronically.***

11) Section I E. states "DSHS will conduct one round of rate negotiation after awarding contracts and allowing bidders to review high level summaries of other tentatively awarded contracts." Does this mean that any cost proposals submitted in the RFP are not binding, especially given the potential changes to the covered population based on other bid awards? ***Yes. However, we would expect any adjustments to the bid rate to be explained in detail during the negotiation process, and will not award a contract to a bidder who presents an unrealistic rate in the initial proposal in order to secure a contract.***

12) Are payments for Predictive Modeling and referrals to LCMs based on total costs as incurred or pmpm over a given time period (Section I.E.2.)? ***See question VII.8 above. We are requesting a separate rate for this activity and will pay pmpm***.

13) In Governor Gregoire's January, 2006 directive, she notes a desire to create "an environment that fosters and rewards improved care." What rewards are being considered for patients, providers or both? (Page 7) ***Financial rewards or incentives should be built into the medical home model for LCMs; in general, clients can be given non-monetary incentives.***

14) Page 14 of the RFP, Section I.E. states, "the SCM Contractor shall be paid for Predictive Modeling services and referral of eligible clients to Local projects as described in this RFP. The SCM Contractor shall be paid *a separate* per member per month fee for care management services to identified high risk clients who do not reside in a Local program service area. (emphasis added)" The instructions for the SCM Cost Proposal on page 35 states, "Propose *a per member per month (pmpm) rate to deliver all necessary Care Management services*. This rate will paid only for clients actively engaged in care management as evidenced by monthly client specific reports. The pmpm rate will include the development of the project and data management, *including Predictive Modeling* (emphasis added)." Can DSHS please clarify if bidders should submit only a single PMPM cost, or proposed a separate fee structure for services such as predictive modeling which are not included in the PMPM fee for managing high risk members who reside outside of the areas covered by the LCMs? ***See answer to question VII.7.***

15) p. 14, Section E.2 states SCM shall be paid for Predictive Modeling services and referral to Local projects. The SCM shall also be paid a <u>separate</u> PMPM fee for case management services. However, p. 35 Section F.I.1 states to propose a

PMPM rate to deliver all necessary care management services. The PMPM rate will include Predictive Modeling. Please clarify. ***See answer to question VII.7.***

16) On page 14 in Section E.2, there is discussion that the SCM will be paid for predictive modeling services and referral of eligible clients to LCM projects and that the SCM will be paid a separate per member per month fee for care management services. Then on page 35 under the section regarding the cost proposal for SCM contractors, there is only discussion regarding the per member per month fee for care management services. Please clarify how the State would like the pricing from the SCM to reflect the costs for both the care management services as well as the predictive modeling services and referrals to LCM contractors. ***See above answer to question VII.7.***

17) What is the definition of LCM enrollees or clients for the purpose of PMPM estimates, bid and payments? For example:

i. Does the enrollee count include clients referred by the SCM contractor who have a PCP that is not a member of the bidder's network, but who need and receive case management assistance? ***Yes.***

ii. Is there a means to charge for costs incurred in attempting to contact and involve clients referred who ultimately are unreachable or unwilling to participate? ***Yes, as Basic.***

18) E, Page 14 Which criteria will be used to define "eligible clients who agree to be enrolled and participate in the program?" ***See above answer to question 7, also put into your proposal how you would document their consent to participate.***

19) Page 14 of the RFP, Section I.E. implies that the SCM contractor will do predictive modeling and referral services, and care management services for high risk clients who do not reside in an LCM service area. If the SCM is allowed to provide a comprehensive community-based care management approach beyond the minimum requirements of the RFP (e.g. telephonic engagement, time-limited education, etc.), it is not clear how the full scope of the SCM's services should be reflected in the proposed PMPM cost. Can DSHS provide more information on the full scope of services allowable for an SCM to promote evidence-based care consistent with the Chronic Care Model, and elaborate on how this should be addressed in SCM PMPM costs? ***The proposal should provide a cost-effective approach to chronic care mgt. If the additional costs related to activities described here will be offset by cost savings, then the proposal may be awarded. The proposal will need to carefully describe how the cost effectiveness has been estimated.***

20) Must the PMPM bid be a constant for all categories and management complexity levels among eligible clients? ***Yes, but also see response to question VII.7.***

21) E2, Page 14 Please clarify what the state means by "support for participating providers as medical homes." ***This should be included in your proposal.***

22) I3, Page 36 In creating the response for this question, should we assume there are 5,000 clients enrolled across all LCMs, or 5,000 in each of the LCMs? If we assume there are 5,000 in each, should we also assume there are three LCMs (total of 15,000 LCM enrollees)? ***5000 total.***

23) On page 15 in Section F, there is discussion regarding reports, specifically a monthly report of all enrollees engaged in the care management intervention. Are the LCM and SCM contractors paid for enrollees who have open cases at any time of the month, at the beginning of the month, at the end of the month, or some other benchmark? ***Enrollment is monthly. Cases would have to be open at a cut-off date (usually about the 15th of the month in order) in order to be paid for that month.***

24) Must the PMPM bid be a constant through the two year period, or can it be graduated on a pre-determined schedule that takes into account expected cost inflation or accelerated recovery of eligible start-up costs? ***Will be constant throughout 2 years.***

VIII. Evaluation and Reporting

1. To what data from the SCM's predictive modeling (Section C. 8) will the LCMs have access? How frequently will reports be available? (this information will be necessary for the LCMs to comply with the evaluation and Quality Assurance and Improvement provisions of the program.) ***The products of predictive modeling will be available according to HIPAA rules – in general, rolled up data shared freely, individual level data as needed for client management. This is a good item for the post-award negotiation phase.***

2. One of the goals of the program is to improve the overall health of the enrollee. How is this to be measured? ***Bidders should describe a proposed method for measuring health status in the proposal. A standardized tool, e.g. SF 8, would be preferred.***

3. Will DSHS provide detailed expected formats and data elements for each required report? ***We have examples of reporting tools we have used for other purposes, but are not committed to any specific tool at this point. We will specify tools and data elements in the contract.***

4. Item 3 under section II D refers to "Section H, Evaluation and Reporting". Is this supposed to refer to Section F since there does not appear to be a Section H with that title? ***Yes.***

5. Will DSHS keep the LCMs and SCM in the loop on the financial progress of the program through the quarterly reports they will be generating? ***Yes.***

6. Will LCMs have access to the reports (blinded) of results for the other LCMs? ***Yes, good idea.***

7. How will improved health outcomes be measured and tracked (Section I.F.2.)? ***We have examples of reporting tools we have used for other purposes, but are not committed to any specific tool at this point. We will specify tools and data elements in the contract based on what is contained in apparently successful proposals.***

8. Page 10 of the RFP, Section I.C.5.c.iv. states LCM contracts require "entering enrollee-specific data directly into the provider's information system or directly into the enrollee's medical record." Can DSHS please elaborate on how data is to be aggregated across various provider information systems to support reporting and other requirements of the LCM (versus provider) role in the chronic care process? ***We will devise a means for this before the program is implemented.***

9. Please clarify if any specific metrics have been assigned to the Evaluation and Reporting criteria for the following on Page 15:

    a. F(2)(c) – Increase the number of enrollees appropriately referred to mental health & chemical dependency treatment. What percent increase will be expected? ***This has not been determined. Would have to be measurable so size of projects will make a difference.***

    b. F(2)(d) – Improve overall health status. How will this be measured? ***A standardized tool would be preferred, e.g. SF 8 built into assessment.***

10. Page 10 of the RFP, Section I.C.6.a.i.f. requires participating providers to "provide outcome data (e.g., lab results) by disease." Does DSHS desire LCMs to have the ability to aggregate data, by disease state, for individual medical home providers? ***Yes.***

11. Page 12 of the RFP, Section I.C.8.f. addresses reporting requirements. Is the report of "Top 25% of utilizers" specific to numbers of services (e.g. inpatient, pharmacy), or is the report top utilization in aggregate terms (i.e. total costs)? Can DSHS please elaborate on what is expected for utilization profiles? For example, are consolidated utilization profiles identifying primary diagnosis and co-morbidities acceptable? ***Please describe in your proposal what you would provide and what would be useful to DSHS and the LCM's.***

12. Page 15 of the RFP, Section I.F.2. refers to "specific goals for the program." These goals include increasing the number of medical home assignments. What is the current baseline for medical home assignment, or how can this data be determined from administrative claims data provided pursuant to the Data Sharing Agreement? ***On the initial assessment of clients, a new baseline will be established. There is no current baseline.***

13. p. 11, Section C.6.b.iii -- What types of enrollee utilization data would DSHS anticipate the SCM vendor providing to physicians? ***Emergency, pharmacy and hospital admits.***

14. Page 8, I.C.3, Since participation by beneficiaries in the chronic care management program will be voluntary, how will program effectiveness be measured if fewer beneficiaries than anticipated agree to participate in the program? Or, what is the state's estimate of how many of the 20,000 disease management participants will agree to participate in this new program (i.e., anticipated overlap)? How will such an outcome be imputed to the each contractor? ***The program's overall effectiveness will be evaluated on the overall success for the population, whether actual enrollment is low or high. We do not have an estimate of the number of previous DM enrollees who would agree to participate. Each contractor will be evaluated for their ability to affect the population in their area.***

15. Page 28, III.2.A.5.b, Given that the State wishes to graduate participating clients within six months of enrollment, how will the State adjust client and program performance for the claims payment lag? How long do providers have from the date of service to submit a clean claim timely? ***Providers have 12 months to submit claims. The program will be evaluated using a 6 month claims lag***.

16. F2, Page 14 Who will calculate the baseline indicators for benchmarking those program specific goals as outlined in the "evaluation" section? ***Certain benchmarks can be established with claims data prior to the program start, and those can be calculated by DSHS. Others will need to be established once the program begins and outcomes data can be collected***.

17. On page 15 in Section F.3, there is discussion regarding certain information that must be reported by the LCM and SCM. Are there pre-defined lists of race and ethnicity categories, and if so, what are those categories? What is expected in terms of "disease profile" for reporting purposes? ***DSHS does use a specific set of race/ethnicity codes which reflect the following categories: Asian (includes Native Hawaiian or other Pacific Islander), Black, American Indian, Hispanic, White, Other, Unknown. The disease profile could be standard groupers or certain specific disease categories or clusters of diagnoses.***

IX. Other

Several bidders asked about current pilot projects – The Washington Medicaid Integration Partnership (WMIP), the Medicare/Medicaid Integration Project (MMIP). Following are brief descriptions of the projects with their location.

- WMIP is a risk-based managed care program that combines full scope medical and mental health, outpatient drug and alcohol treatment and long term care services into a single integrated managed care plan. The program is located in Snohomish County, Washington and serves SSI enrollees. The program also contains a robust care coordination component;

- MMIP is a risk-based managed care program that combines full scope medical and long term care services in a single integrated managed care plan. The program serves dual Eligible, Medicare/Medicaid clients and is located in King and Pierce Counties. This program also contains a robust care coordination component.

1. If LCMs are allowed to outreach to other clients for enrollment in this program, what are the provisions to exclude WMIP, MMIP, PACE or the GA-U members from that process? ***MMIP, WMIP and PACE are voluntary Medicaid programs. Clients will not be prevented from learning about their options to enroll in the care management projects. GAU and Healthy Options clients are not eligible for this project.***

2. **p. 6, Section A –** Where are the existing pilot projects located? ***Snohomish, King, Pierce counties.***

3. Page 6 of the RFP, Section I.A.2.a. references "existing pilot projects." Can DSHS please provide a complete listing of these projects with associated details, including the location and the scope of the work under these projects? ***Please see above.***

4. P. 6, I.A.2.a, What other existing DSHS pilot programs are operational that "seek to improve management of the aged, blind and disabled population?" Please list and describe the scope of work requirements of each interface with them. ***Please see above.***

5. Section C. 4 d refers to outreach to and enrollment of potential enrollees. Does this mean that the LCM can market to these potential enrollees? Are there parameters for what is allowed in these marketing activities? ***CMS does not allow "marketing" per se to Medicaid populations; however, outreach is an allowable activity. Outreach activities must provide the same information to all***

enrollees or potential enrollees and cannot contain any inducement (beyond improved health outcomes and quality of life) to enroll.

6. Will DSHS provide supporting information for rate determination such as number of enrollees in the previous disease management model? ***Yes.***

7. Given that cost neutrality is a requirement, how will bidders be advised of the current cost of serving these members to ensure cost neutrality (it is assumed that the "cost" is more than just total claims paid due to current disease management costs)? ***DSHS would be happy to share cost information submitted to CMS with bidders; "cost" includes the cost of operating the program in addition to claims costs paid by DSHS.***

8. How soon after the submission of the Data Sharing Agreement will DSHS provide the claims information? What format will that information be in? ***We will provide examples at the bidders' conference. We anticipate the data being available August 1. The files will be CSV format****.*

9. Rather than developing a new program, has the state considered expanding current programs such as WMIP, MMIP or PACE to other areas, perhaps adding some of the enhancements mentioned in the RFP? ***Yes; however, we have a commitment to evaluate WMIP/MMIP before expansion.***

10. Exhibit B Page 46 According to this table, it appears that there are 180,735 individuals eligible for the program. Is this correct? If not, is there duplication in the numbers in each column? ***The dual eligible clients are not eligible for the SCM program. There are no duplicate clients, however these are annual numbers, not monthly averages****.*

11. Exhibit B, Page 46 Would the State please clarify the definition for Client Count as presented in Exhibit B Medicaid/Dual Eligible ABD members? Are these program users or all eligible members? ***These are eligible clients of DSHS.***

12. Exhibit B, Page 46 What is the expected annual growth rate for the Medicaid/Dual Eligible ABD population in Washington? ***We project a growth rate of 2% per year in the ABD population over the course of this contract.***

13. Exhibit B, Page 46 Are all of the Medicaid/Dual Eligible ABD members listed on Exhibit B eligible for inclusion in the new Chronic Care Management Project? OR does this list include members who may be ineligible due to exclusion criteria? ***The dual eligible clients are not eligible for the SCM program.***

14. 10. Please define "DASA" as referenced on Page 16. *"****DASA" is the DSHS Division of Alcohol and Substance Abuse.***

15. Page 6 of the RFP, Section I.B. references current "DM programs through statewide contracts." Will DSHS provide information on the size, scope, time limitations of the contract etc of the existing DM program, including current financial and statistical data or program reports, and elaborate on how the two DMO contracts will be transitioned into the new program? Since the current vendor has all the information above, making this also available to other bidders will create a fair and equal distribution of all available public information, and competitive environment, for all potential bidders. ***There is currently no disease management program operating in the State of Washington. The new program as described in the RFP is very different from the previous program, so many of the reports generated during the previous contract period would not provide much information that would be useful to current bidders. However, we will post the public reports on the RFP website.***

16. Page 14 of the RFP, Section I.E. references "CMS rules under waivered programs" regarding tracking utilization of services. Could DSHS provide specific references (e.g. CFR cites) to these applicable federal regulations that are expected to apply to SCM or LCM contractors? ***CMS rules for managed care (Prepaid Ambulatory Health Plan) may apply for cost effectiveness.***

17. Page 15 of the RFP, Section I.E. indicates "high level summaries" are available during "one round of rate negotiation after awarding contracts." Does DSHS prepare these summaries, and what information is to be included on these summaries? ***Yes, we will provide the geographic area covered by the LCMs and the numbers of enrollees in those areas. We will also provide information on what the Predictive Modeling is expected to provide to the LCMs in terms of referrals and reports.***

18. Page 34 of the RFP, Section III. E. addresses Management Experience and Qualifications for both SCM and LCM Bidders. Question 5 indicates that the both SCM and LCM bidders should "provide resumes for the named staff that include information on the individual's particular skills related to this project, education, experience and any other pertinent information." For an SCM bidder not currently operating a care management program in the State of Washington, the key staff will be recruited locally but a bidder would not hire staff for a project until it is actually awarded the contract. Question 9 instructs both SCM and LCM bidders to "describe the qualifications of the staff who will provide care management interventions, including current resumes of staff who will be assigned to the project. Provide job descriptions for each care management role, and the number of FTEs in each role per 1000 client caseload." Again, a bidder not currently operating a care management program in the State of Washington would not hire staff for a project until it is actually awarded the contract. In order to assure a competitive solicitation for bidder's not currently providing these services within Washington, will DSHS modify this requirement to consider that position descriptions, staffing levels etc are sufficient in lieu of actual resumes,

with experienced corporate implementation staff identified in key interim roles in the project? ***Provide specific information for those positions in which staff has already been identified; for all others provide specifics of the position and staffing levels.***

19. p. 19, Section II.6 -- In lieu of identifying pages with proprietary information, would DSHS be willing to consider a redacted version of the proposal, accompanied by a highlighted version and a detailed confidential treatment request? ***Yes.***

20. Could DSHS confirm that we will include the technical and cost proposals in the same binder, and ship them together? ***Yes, as long as they are clearly identified***.

21. Can the acceptance of volume be graduated in order to accommodate a ramp-up of high quality services to higher capacity following execution of a contract? ***Yes, that information should be included in the bidders implementation timeline.***

22. Can subcontractors for services included in the bid be adjusted during the two years based on market changes or better understanding of client needs? If DSHS approval of such changes is required, what will the process be? ***Yes, Contractors can make changes based on experience gained in providing services; DSHS will require prior notification of the change (if possible) and will also require that enrollees directly affected by changes are notified of the change. By changes that directly affect enrollees, we mean providers in the network, care management nurses or lay workers who have contact with enrollees on an ongoing basis, or others of that nature.***

23. Will LCM contractors receive data only through the SCM contractor, or will they also have the ability to request data directly from DSHS? ***DSHS will provide data specific to region, but the data will not differ significantly from the data provided through the SCM.*** What data can be expected and how timely? ***Monthly.*** While LCM contractors will be expected to report on enrollee utilization, in fact the DSHS data will be necessary as a cross-check and to provide pointers to additional points of service that may not have been discussed with case managers. Will information available include medications dispensed, emergency department visits and inpatient admissions? ***Yes.***

24. 16. We note that if all information is controlled by SCM, that organization will have a competitive advantage in bidding that may detract from the ability of the LCM model to succeed financially and receive a positive evaluation. Does DSHS have any plans for means to mitigate this information asymmetry? ***All the data will not be controlled by SCM***.

25. Does DSHS have a hospital precertification or preauthorization process and can share that data with a successful bidder to help identify and manage clients when

they have a hospitalization? ***There is no precertification or preauthorization for most hospitalizations covered by DSHS.***

26. Does DSHS have a primary care case management (PCCM) or similar program where it pays participating physicians a fee on behalf of each client enrolled with that physician to help improve the quality of services? ***Not for this target population.***

27. Will DSHS allow bidders to develop pay for performance incentives for physicians and have these payments be reimbursed by DSHS and excluded from the cost neutral evaluation? ***No.***

28. DSHS mentions it has received feedback and actively solicited input from providers who have felt somewhat disengaged in the original disease management program. Can DSHS share in more detail the lessons learned with respect to provider engagement? ***Our summary report will be made available at the bidders conference and on request.***

29. Has DSHS considered and is receptive to a more active involvement of pharmacists, who often see chronically ill patients more often than physicians? ***That would be an acceptable addition to the program – tell us how you would utilize pharmacists.***

30. To what extent will DSHS allow bidders to include incentives for clients to incent them to adopt health behaviors? ***In general they have to be small non-monetary such as gift cards for local grocery stores.***

31. Will DSHS use an outside consultant or other entity to evaluate the RFP responses, and if so, tell us who that is? ***No.***

32. Will DSHS use an outside consultant or other entity to evaluate the program success, including cost neutral calculations, and if so, tell us who that will be? ***If CMS requires an evaluation by an outside entity, DSHS will contract for those services; if not, the evaluation may be provided by the DSHS Office of Research and Data Analysis or another internal resource***.

33. Will DSHS be willing to provide the most recent 3 years of claims history so that bidders can use that to build more robust predictive modeling programs? ***No, not for the purposes of this RFP; given the high rate of turnover represented by the data, this information would not be useful for the current bidders.***

34. Data Disk Given that the data disk for SCM offerors will not be available until after this question submission period ends, will the State conduct a separate Q&A to respond to issues identified regarding and clarifying information on the data disk? ***Yes, bidders will be given one week to ask questions regarding the data***.

35. P. 9, I.C.5.a.a-c Please clarify the difference, if any, between a medical treatment plan and a care plan. ***A medical treatment plan is the one created by the physician or nurse practitioner. "Care plan" is defined in the RFP***.

36. C5b and c, Page 9 What is the difference between a medical treatment plan and a care plan? ***See question above***.

37. P. 10, 29, I.C.5.b.iii, III.E.2.B.2, If it is determined that a client will be re-eligible to participate in the program at some point after graduation, will the State consider this to be a separate intervention, and pay the LCM for such reentry into the program? ***Yes, this would need to be an approved process as the extension of a client beyond 6 month intervention is approved by DSHS***.

38. P. 11, 31-33, I.C.7, E.3 Please confirm that an offeror bidding as an SCM is not required to submit responses to the LCM scope of work portion of questionnaire section 3 on pages 31 through 33 of the RFP? ***Correct.***

39. p. 12, I.C.8.g, Will the State be willing to sign a confidentiality agreement and agree to restrict its review to a visual review of programming logic and algorithms, without taking or retaining the information reviewed? ***That is an item for negotiation and discussion with our attorneys.***

40. P. 19, II.D Which Tribal Organizations, Counties or Local Health Jurisdictions participated as subcontractors in the disease management program? Please provide a list and contact information. ***None of these organizations participated in the previous program***.

41. p. 25, III.C, May the optional electronic copy of the proposal be presented in an Adobe Acrobat format? This will make it easier for offerors in assembling their final documents. ***Yes, the electronic copy may be submitted on Adobe Acrobat format***.

42. Page 34, III.E.E.3 Please clarify the lettering sequence beginning at Section 3. The previous section is identified as E., and duplicated again on page 34 of the RFP. ***Apparently a technical glitch occurred on the numbering of those sections. We will number them correctly and send a copy with the electronic copy of the bidder questions/answers and related information.***

43. Page 28, III.2.A.5.b.i Please clarify the numbering sequence. ***The numbering sequence should only contain one 5.b.i. See answer to question 43, above.***

44. Page 34, III.E.E.1 What level of services is anticipated to be in place by January 1, 2007 – full services or incremental services, with full services implemented by June 1, 2007? ***The bidder's timeline should describe how the services will be implemented. If the bidder does not expect to be at full capacity by January 1, there must be a specific plan in place to attain full capacity by June 1, 2007***.

45. Exhibit C, Noting the exiting confidentiality provisions in the Terms and Conditions, will an offeror be required to execute a Business Associate Agreement with DSHS? ***No.***

46. E, Page 14 Would the State further define all of the HIPAA-compliant requirements of contractor needed to bill DSHS for its services? ***The contractor would need to be able to receive and read the 820 and 834 transactions and all associated transactions(s).***

47. E46 and 7, Page 34 If the proposer is a subsidiary of a larger organization (and does not have a separate advisory board), should these responses discuss the board of the larger organization, or focus on the proposer's executive team? ***The proposal should contain a brief description the larger organization's board of directors, but should focus on the actual bidder's executive team. It's whoever will be directly involved in the program.***

48. D3, Page 32 Will the State please clarify if Question 3 is referring to Section F Evaluation and Reporting? ***Yes.***

49. E4, Page 35 This question requests references, which appears to be a similar requirement to page 26, requirement D.4. Should the proposers list the same references in two places in our bids? ***Provide the references once, in your response to Section E.4.***

50. p. 34, Section III.E.2.E.4 -- This question requests references from previous Medicaid projects. The same request appears in Section III.D on p. 26. Is this an additional request for references, or should the bidder provide the same references in response to both questions? ***No, please see the answer to question 49 above***.

51. General - Would the State please provide a copy of the previous contract, including contract value, detailing these services as provided by the previous vendor? ***Yes, we will be happy to provide previous contracts; however, bidders should keep in mind that the service descriptions and details in newly awarded contracts will be significantly different from the previous program contracts***.

52. General Please explain the State's current process for assigning Medicaid eligibles to a PCP, and whether there is an enrollment broker or other entity directly responsible for this assignment. ***Fee for service clients are not assigned to PCPs***.

53. General - Is there any incentive for physicians or other providers to participate in Medicaid and serve Medicaid clients, beyond the standard fee for service payments? ***No.***

54. General - Will the State please clarify if IHS Medicaid clients will be included in this program? ***If by IHS, you mean Indian Health Services, then yes, those clients may be included in the program on a voluntary basis***.

55. Data Will the monthly data provided include provider data - specifically provider participation (eligibility) dates, primary care physician status, specialty, and geographic information? ***Yes, provider data can be provided. It does not contain PCP information.***

56. Data Would the State please provide a data dictionary for the data provided? ***We will post the data dictionary on our website.***

57. On page 34 in section E, there is a description of the management, experience, and qualifications for the proposal response. Are there any minimum qualifications that the LCM or the SCM contractors must possess, such as Medicaid specific experience? ***Medicaid experience would obviously be helpful in managing our clients; however it is not required***. ***Minimum requirements would include appropriate licensure or certification to provide services***.

58. What are the names of all of the organizations that submitted questions regarding this RFP? ***That list has already been disseminated to the bidders.***

59. Who were the attendees at the bidders' conference? ***The list will be provided after the bidders conference.***

60. Can you describe the "flexibility" of the Medicaid regulations for this project – ***Any flexibility in the Medicaid regulations will be determined after Contracts have been awarded and the program specifics determined. Generally, anything that "flexes" from Medicaid regs would result in a waiver***.

61. Page 14, E.1. - What is your payment flexibility, since you will be doing the claim payments. ***DSHS will pay claims according to published billing instructions.***

62. What is the incurred period for the pmpms shown on Exhibit B of the RFP? ***Incurred during SFY 2005, paid through March 2006***.

63. Are the cost and utilization components of the Exhibit B pmpms available by type service (Inpatient, Outpatient Emergency Room, Office visits, etc.)? ***Complete data available per instructions in RFP.***

64. C3i, Page 8 Would the State please clarify or provide a listing of services included (for example Nursing Home Residents, etc.) for all included in the home and community based long term care services case managed by the Aging and Disability Services Administration? ***See below:***

Long-Term Care Services (not exclusive list):

Adult Day Care: A supervised daytime program for adults with medical or disabling conditions that do not require the level of care provided by a registered nurse or licensed rehabilitative therapist. Services include personal care, social services and activities, education, routine health monitoring, general therapeutic activities, a nutritious meal and snacks, supervision and/or protection for adults who require it, coordination of transportation, and first aid and emergency care.

Adult Day Health: A supervised daytime program that provides skilled nursing and rehabilitative therapy services in addition to adult day care. An adult day health center provides skilled nursing services, rehabilitative therapy such as physical therapy, occupational therapy or speech-language therapy and brief psychological and/or counseling services and all of the services listed for adult day care above.

Caregiver/Recipient Training Services: Training services are mandated for each COPES paid caregiver and provide instruction in either a one-to-one situation or in a group setting.

Personal Care Services: Services provided for enrollees who are functionally unable to perform all or part of such tasks, or for enrollees who cannot perform the tasks without specific instructions. Personal care services do not include assistance with tasks that are performed by a licensed health professional. Personal Care Services may include physical assistance, and/or prompting and supervising the enrollee in performance of direct personal care tasks and household tasks. Individual or agency providers perform these duties.

Personal Emergency Response System (PERS): An electronic device is provided that allows clients to get help in an emergency. The system is connected to a phone or the enrollee may also wear a portable "help" button. When activated, staff at a response center will call 911 and/or take whatever action has been set-up ahead of time.

Residential Programs:

Adult Family Homes: Adult family homes are residential, neighborhood homes licensed by Washington State to care of two to six people. Adult family homes provide lodging, meals, laundry, and organized social activities or outings. If it is needed, they also provide necessary supervision, assist with personal care (getting dressed, bathing, etc.) and help with medications. Some provide nursing care or may specialize in serving people with mental health problems, developmental disabilities, or dementia.

Boarding Homes: Boarding homes are larger facilities licensed by Washington State to care for seven or more people. Boarding homes provide lodging, meal services, assistance with personal care, and general supervision

of residents. Some provide limited nursing care or may specialize in serving people with mental health problems, developmental disabilities, or dementia.

Nursing facilities (Homes): Provide 24-hour a day supervised nursing care, personal care, therapy, nutrition management, organized activities, social services, room, board, and laundry. Short term stays in lieu of hospitalization will not be an exclusion for this program.